January 2016

CALDERDALE AND KIRKLEES CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2014/15

Calderdale Safeguarding Children Board

Kirklees Safeguarding Children Board

Authors: Calderdale and Kirklees CDOP members

Executive Summary

Calderdale and Kirklees have operated a joint CDOP since 2008, when the child death review process became a mandatory function. The Child Death Overview Panel (CDOP) is designed to meet the functions set out within Together to Safeguard Children, 2015.

The panel met six times in the year, and has a permanent core membership drawn from the key organisations represented on the two Local Safeguarding Children Boards.

The CDOP conducts reviews of each child death in order to better understand the factors that have contributed to the death. By so doing, the panel seeks to prevent avoidable deaths and improve the health and safety of children.

A total of 15 deaths of children were reported to Calderdale Child Death Review Team between 1 April 2014 and 31 March 2015. This is the lowest number recorded since the introduction of Calderdale CDOP.

Thirteen Calderdale cases were finalised at Panel during 2014-2015 (some from this year and some from previous years). Of those, 38% were noted as having modifiable factors, consanguinity being the most significant factor.

A total of 36 deaths of children were reported to Kirklees Child Death Review Team between 1 April 2014 and 31 March 2015. Again, this is the lowest number recorded since the introduction of Kirklees CDOP.

31 Kirklees child deaths were reviewed and completed between 1st April 2014 and 31st March 2015.

There were 13 Sudden Unexpected Death in Childhood (SUDIC) cases across Calderdale and Kirklees during the year.

During 2014/15 the CDOP undertook the recommendations from the previous year's report. These included work to understand the scale of emotional health and wellbeing issues in children, engaging in regional and national networks, promoting of a child safety e-learning package, work to improve the relationship between CDOP and coroners, improving child death review training, raising the quality of Form B's and establishing a bi-annual CDOP newsletter.

The CDOP has also established a series of recommendations for the year 2015/16. These include improving the CDOP process, continuing a focus on emotional health and wellbeing, a focus on smoking as a modifiable factor (including use of e-cigarettes), a focus on consanguinity as a modifiable factor and a retrospective review of modifiable factors from the previous five years.

Contents

1 Introduction

The Child Death Overview Panel (CDOP) is designed to meet the functions set out within Together to Safeguard Children, 2015. These include:

- reviewing all child deaths from age 0-17 excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future deaths
- identifying patterns or trends in local data and reporting these to the LSCB
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of Serious Case Review
- cooperating with regional and national initiatives to identify lessons on the prevention of child deaths

The CDOP conducts comprehensive and multidisciplinary reviews of each child death in order to better understand the factors that have contributed to the death. In particular, the panel seeks to understand whether modifiable factors either caused or contributed to any child deaths. Modifiable, in this context, means factors that we can address to reduce the likelihood of future occurrence. The CDOP promotes information about how to reduce the likelihood and impact of modifiable risks within the health and social care system and with other stakeholders such as schools. By so doing, the panel seeks to prevent avoidable deaths and improve the health and safety of the children in the two localities.

This report covers the 2014/15 accounting year, up to the end of March 2015.

The purpose of the report is:

- to summarise the cases reviewed by the CDOP over the year
- to highlight the key modifiable factors identified by the CDOP
- to review the delivery of the actions identified from the previous annual report
- to identify the actions that should be taken in the year to come

For further information on the work of the CDOP please contact:

Calderdale Safeguarding Children Board
Child Death Overview Panel
Northgate House
Northgate
Halifax
HX1 1UN

☎ 01422 394074

Kirklees Safeguarding Children Board
Child Death Overview Panel
3rd Floor, Somerset Buildings
10 Church Street
Huddersfield
HD1 1DD

☎ 01484 225450

2 CDOP membership & meetings

Calderdale and Kirklees have operated a joint CDOP since 2008, when the child death review process became a mandatory function. Individuals from the respective safeguarding children teams work in partnership to manage the process, with the chair and venue of the panel alternating between the two localities.

The panel met six times in the year, which is consistent with other geographical areas locally and nationally. The Child Death Overview Panel has a permanent core membership drawn from the key organisations represented on the two Local Safeguarding Children Boards. Other members are co-opted to contribute to the discussion of certain types of death when they occur.

For the Child Death Overview Panel to be able to carry out its duties in reviewing the deaths of children, the following representatives are required to be present in order for the CDOP meetings to be quorate:

- The Chair of the Child Death Overview Panel
- SUDIC Paediatrician
- Police or Coroner's officer
- Consultant, Public Health
- Principle Officer, Child Protection
- Designated Nurse for Safeguarding
- Representative from both Calderdale and Kirklees Safeguarding Children Board

Current panel membership (as at January 2016) is as follows:

Panel Member	Role and Agency
Caroline Rhodes	Manager, Kirklees Safeguarding Children Board
Julia Caldwell	Business Manager, Calderdale Safeguarding Children Board
Dr Eilean Crosbie	Consultant Paediatrician, Calderdale and Huddersfield NHS Foundation Trust
Dr Brigid Allagoa	Consultant Paediatrician, Mid Yorkshire NHS Foundation Trust
Nicky Hoyle	Consultant in Public Health, Kirklees Council
Ben Leaman	Consultant in Public Health, Calderdale Council
Gill Poyser-Young	Designated Nurse (Safeguarding), Calderdale & Kirklees

Joyce Ayre	Named Midwife, Calderdale and Huddersfield NHS Foundation Trust
Tomasina Stacey	Named Midwife, Mid Yorkshire NHS Foundation Trust
Janet Matley	Programme Director for Disabled Children, Kirklees Council
Ann Roli	Disabled Children's Team Manager, Calderdale Council
Joanna Fraser / Karen Bousted	Serious Case Review Officers, West Yorkshire Police
Fiona Turner / Cate Jackson	H.M. Coroner's Office, Kirklees
Daniela Condon / Rodney Holmes	H. M. Coroner's Office, Calderdale
Liz Lyles	Nurse Consultant, Forget Me Not Children's Hospice
Caryn Hansom	CDOP Coordinator, Kirklees Safeguarding Children Board
Julie Hartley	CDOP Coordinator, Calderdale Safeguarding Children Board

Whilst members may change from time to time, the roles do not. The above list is not an exhaustive list of all members that contributed to the work of the panel. A number of panel members have moved on to new roles over the last year and the contribution of those members should be recognised.

3 Data analysis - Calderdale

This section of the report details the work of the CDOP pertaining to the Calderdale population over the last year, highlighting both the work of the panel and the more general context of child mortality in Calderdale.

3.1 Deaths reported to the Calderdale CDOP Team

A total of 15 deaths of children were reported to Calderdale Child Death Review Team between 1 April 2014 and 31 March 2015.

This is the lowest number recorded since the introduction of Calderdale CDOP.

Of the 15 reported deaths, 6 have been considered at the Child Death Overview Panel and a conclusion reached in 5 cases.

The remaining deaths will be discussed within the 2015/16 financial year or when sufficient information is available.

In respect of historical reported deaths:

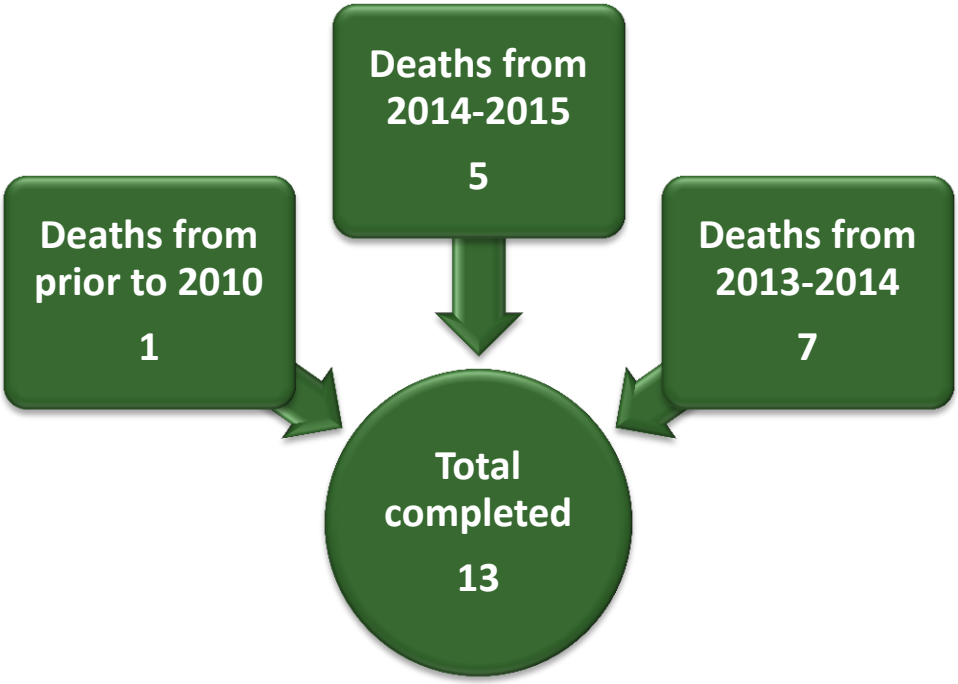
- Of the 38 deaths reported to the Child Death Review Panel in 2008-2009, a conclusion has been reached in all cases
- Of the 24 deaths reported in 2009-2010, a conclusion has been reached in all cases
- Of the 25 deaths reported in 2010-2011, a conclusion has been reached in all cases
- Of the 17 deaths reported in 2011-2012, a conclusion has been reached in all cases
- Of the 17 deaths reported in 2012-2013, 15 cases have been reviewed, and a conclusion has been reached in 15 cases
- Of the 19 deaths reported in 2013-2014, 17 cases have been reviewed, and a conclusion has been reached in 16 cases.
- Of the 15 deaths reported in 2014-2015, 6 cases have been reviewed and a conclusion has been reached in 5 cases.

13 cases were finalised at Panel during 2014-2015 (including cases outstanding from previous years). The details of the completed reviews are set out below.

3.2 Child Death Reviews Completed at CDOP

13 Calderdale child deaths were reviewed and completed between 1st April 2014 and 31st March 2015.

5 of the deaths occurred within this timeframe; the others were outstanding cases from previous years which had been awaiting further information or awaiting investigations, inquests or reviews.



Of the deaths occurring between 2008-09 and 2012-13, 15% of cases had modifiable factors or potentially modifiable factors.

At that point, CDOP revised the method of categorising deaths in order to provide a fuller and more complete picture. As a result, in 2013-2014 the figure was 37%. This makes it look like we saw a sudden increase in modifiable deaths, which was not the case.

Of the cases completed in 2014-2015, 38% were noted as having modifiable factors against the national average of 24%. This is broadly in line with the previous year.

Consanguinity was noted as a modifiable factor in 23% of completed cases (3 out of 13). Emotional / behavioural / mental health condition in parent / carer was noted in 15% of cases (2 out of 13). Alcohol / substance misuse by parent, smoking in pregnancy and domestic violence were all noted in 8% (1 out of 13) of cases.

Poor parenting / supervision was noted as a modifiable factor in one death, as was “other disability or impairment of child”.

The panel recommended further investigations were done on some cases, but no issues relating to service provision were raised by the Panel.

There was some variation from previous years in respect of the cause of death, which is always likely given the small numbers of cases.

“Chromosomal, genetic and congenital abnormalities” accounted for the highest proportion of deaths at 54% (34% last year) and “perinatal / neonatal event” decreased to 15% (32% last year) (see below for further detail re: categorisation).

During 2014-2015, there was one Calderdale case completed under category 1 (deliberately inflicted injury, abuse or neglect), which was a serious case review.

Categories of **completed** cases were noted as follows (blanks indicate no cases):

Category of death	2013-14	2014-15
Deliberately inflicted injury, abuse or neglect (category 1)		**1**
Suicide or deliberate self-inflicted harm (category 2)		
Trauma and other external factors (category 3)	**1**	**1**
Malignancy (category 4)		**2**
Acute medical or surgical condition (category 5)		
Chronic medical condition (category 6)		
Chromosomal, genetic and congenital anomalies (category 7)	**11**	**7**
Perinatal/neonatal event (category 8)	**6**	**2**
Infection (category 9)	**1**	
Sudden unexpected, unexplained death (category 10)		
Unknown category		

The **completed** child death reviews were recorded under the following age groups:

Age of child	2013-14	2014-15
0-27 days	**10**	**7**
28 days- 364 days	**≤5**	**≤5**
1 year-4 years	**≤5**	**0**
5-9 years	**≤5**	**≤5**
10-14 years	**≤5**	**≤5**
15-17 years	**≤5**	**≤5**

These figures indicate that 69% of cases concerned children under one year old which is in line with the national average of 66% and the same as last year both locally and nationally.

Whilst the proportion of neonatal deaths increased, actual numbers decreased. There were also decreases within the infant and age 1-4 categories. The proportion of deaths in the 3 higher age group (aged 5-17) categories rose.

As is usual in these cases, the numbers are small and so **caution must be exercised** when considering any emerging trends. The data will be monitored closely to assess any significant changes and measured against the 3 year rolling averages collected by Public Health.

One case completed within 2014/15 concerned a child who was the subject of a Child Protection Plan. No cases were subject to statutory orders.

8 of the **completed** reviews related to male children (62%) and 5 to females (38%). This compares with national averages of 55% and 43% respectively (with 1% unknown).

12 of the 13 **completed** cases were concluded within 12 months of the child's death, which is a rate of 92% compared with the national average of 70%. This is a very positive comparison, especially given that there was a higher than average number of complex cases with modifiable factors to review.

Ethnicity was recorded in 92% of **completed** cases. The categories were noted as follows:

Ethnicity: completed cases 2014/15	
White: English/Welsh/Scottish/Northern Irish/British	**8**
Mixed/multiple ethnic groups: White & Asian	**≤5**
Asian or Asian British: Pakistani	**≤5**
Unknown/not stated	**≤5**

Throughout the period of CDOP operation (2008-2015), approximately 30% of deaths in Calderdale have involved children of Pakistani origin.

Of the **reported**[1] deaths during 2012-2013, 19% were of Pakistani origin. At that time the panel agreed to monitor this data in case a reducing trend became evident.

[1] Note the difference between **completed** and **reported**. Completed refers to cases that were seen and completed by the Panel in 2014/15. This may include cases from previous years. Reported refers to deaths that were reported in 2014/15. They are unlikely to all be seen by CDOP in year.

Of the cases **reported** within 2013-2014, 17% were of Pakistani origin.

Of the cases **reported** within 2014-2015, that figure rose slightly to 20%.

Given the above figures it can be concluded that there is some consistency emerging that does not demonstrate a reducing trend at present but is consistent with a reduction from the historical 30% rate.

The percentage is higher in the number of **completed** cases as some of these deaths occurred outside this timeframe.

The most recent Calderdale Joint Strategic Needs Assessment states that the number of South Asian Children (under 18) as a percentage within Calderdale is 15% (ONS Census, 2011). The percentage of live births in respect of South Asian babies is 17% (CHFT 2013/14). We are therefore likely to see an increase in the proportion of young children from a South Asian background in Calderdale over time.

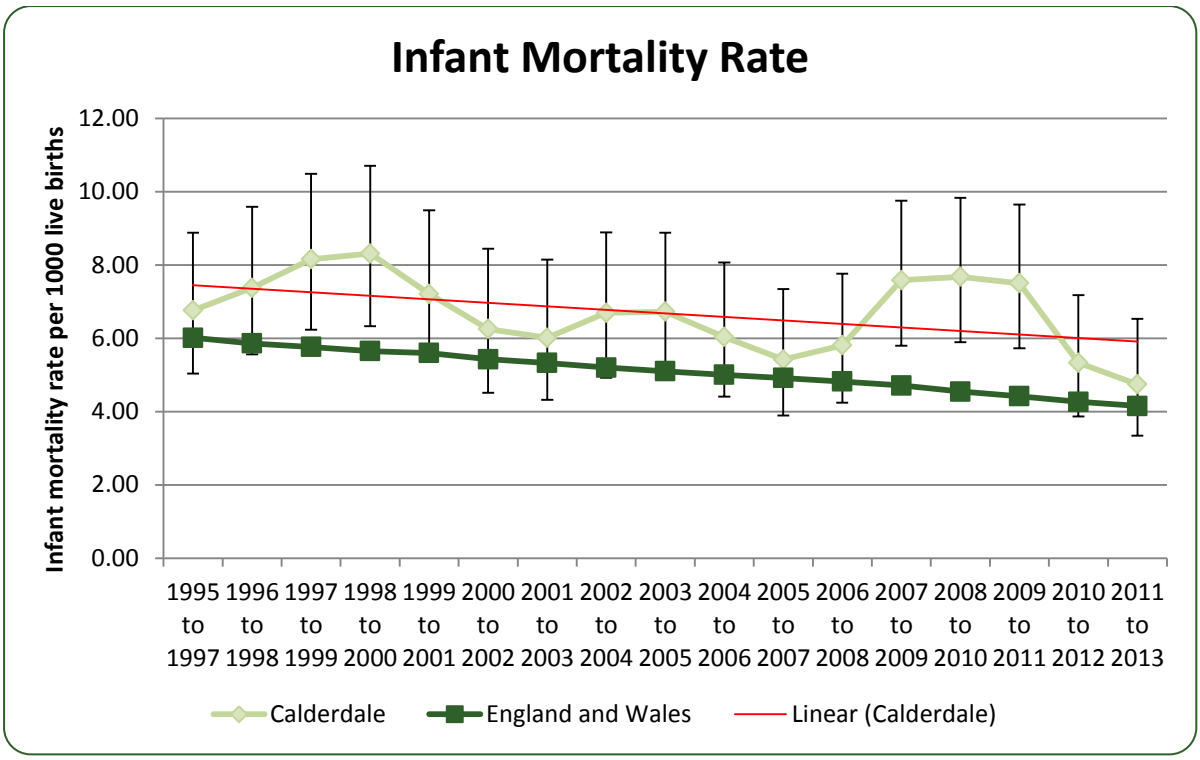
No reported cases in 2014/15 involved the child of an asylum seeking family.

One completed case was the subject of a Serious Case Review by the Safeguarding Children Board. Modifiable factors were noted but no additional recommendations were made. The Serious Case Review can be found www.calderdale-scb.org.uk

3.3 General context of infant and childhood deaths in Calderdale

3.3.1 Infant Mortality (0-1 years)

Infant Mortality rates within Calderdale have been significantly higher in previous years in comparison to both the Yorkshire & the Humber and England & Wales averages. Last year, when the three year rolling data was published for 2010-2012, the rate was no longer significantly higher. The most recent data available for infant mortality rates in Calderdale is 4.7 per 1000 live births, which is a 3-year rate covering 2011-2013. Once again, and continuing last year's positive trend, this is not significantly different from the England and Wales average. Additionally, the rate is the lowest it has been since we started reporting data.



The rate has shown a downwards trend since 1995; however the rate is not decreasing as much as the England and Wales rate, resulting in an increased gap between the two (as shown by the linear trend). As always with infant mortality data, at a local level small changes in numbers of infant deaths can show a large impact on rates.

The neonatal mortality rates follow a similar pattern. The infant mortality rate in Park gradually increased from 10.6 per 1000 in 2001/5 to 14.2 per 1000 in 2007/11. It has now decreased to 9.3 per 1000 in 2009/13 and is no longer significantly higher than Calderdale; however the trend still points towards a higher incidence in Park. There are no significant differences between the other ward rates and Calderdale as a whole.

In summary:

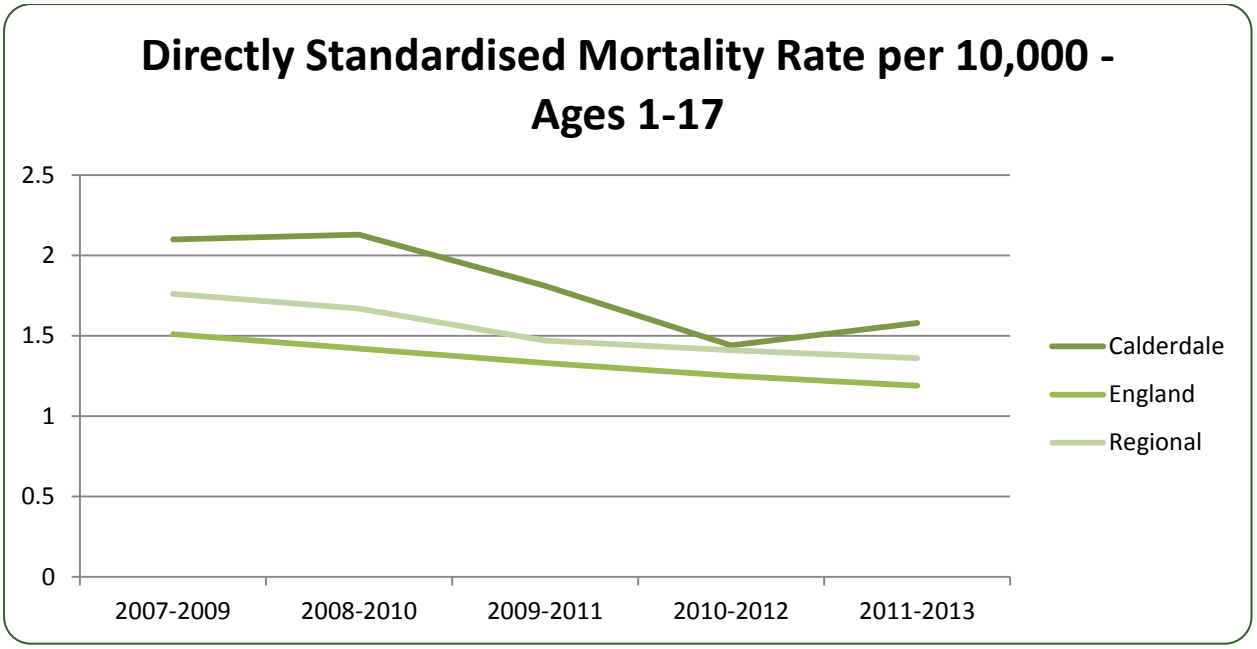
- The majority of child deaths were infant deaths (under 1 year old).
- Prematurity and congenital anomalies accounted for 61% of infant deaths in Calderdale.
- Across Calderdale, 13% of women smoked during pregnancy in 2013/14, compared to 12% in England.
- The still birth rate has shown a downward trend since 2007 and it is now comparable to the England and Wales figure (4.9%)
- Breastfeeding initiation during 2013/14 was significantly higher than for England at 79% compared to 74%

Source: Child health profile 2015, ONS deaths

3.3.2 Child Mortality (1-17 years)

The Child Mortality rates (3 year rolling averages) have been relatively static for Calderdale in recent years, reflecting that of both the Yorkshire and The Humber and England trends. The rate for Calderdale is similar to regional and national rates.

	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Calderdale	2.1	2.13	1.81	1.44	1.58
Regional	1.76	1.67	1.47	1.41	1.36
England	1.51	1.42	1.33	1.25	1.19



From 2012 onwards an ethnicity indicator is no longer available on the mortality datasets - therefore no comparisons could be made by ethnicity. In the past, name recognition software has been used to derive the probable ethnicity of the deceased - however as the mortality data set we receive is anonymised this is also no longer an option. Having access to the ethnicity of the deceased would be valuable for understanding the epidemiology of child mortality. The reasons for not receiving an ethnicity indicator may warrant further investigation.

In Calderdale, child mortality was highest in the 1-4 age range for period 2011-2013 with an age specific rate of 3.19 per 10,000 per year. This age range also had the highest number of deaths over the three year period 2011-1013 (48%).

The lowest Child Mortality rate in Calderdale was in the 5-9 age range for period 2011-2013, with an age specific rate of 1.08 deaths per 10,000. For

Yorkshire & The Humber, the lowest Child Mortality rate for 2011-2013 was in the 10-14 age range.

3.3.3 3 Year Average Age Specific Mortality Rate per 10,000 (2011-2013) Comparison by location

	1 to 4	5 to 9	10 to 14	15 to 19
Calderdale	3.2	1.1	1.1	2.7
Yorkshire & Humber	1.4	1.0	0.9	2.6
England	1.7	0.8	0.9	2.2

3.3.4 Child Mortality Rates 2002 – 2013, by age range

1-4 Age Range: Rates for Calderdale overall are fairly static compared to a slight downward trend across Yorkshire & the Humber and England & Wales.

1-4	2002 -2004	2005 -2007	2008 – 2010	2011 – 2013
Calderdale Average Age Specific Mortality Rate per 10,000	3.2	3.2	2.9	3.2

5-9 Age Range: Numbers are very small.

5 - 9	2002 -2004	2005 -2007	2008 – 2010	2011 – 2013
Calderdale Average Age Specific Mortality Rate per 10,000	0.5	0.8	1.7	1.1

10-14 Age Range:

10 - 14	2002 -2004	2005 -2007	2008 – 2010	2011 – 2013
Calderdale Average Age Specific Mortality Rate per 10,000	1.2	1.5	0.8	1.1

15-19 Age Range: (note data taken from VS files which are categorised as 15-19 rather than 15-17)

15- 19	2002 -2004	2005 -2007	2008 – 2010	2011 – 2013
Calderdale Average Age Specific Mortality Rate per 10,000	3.5	2.9	4.9	2.7

3.3.5 Child Mortality, underlying cause of death 2011-2013

In 2011-2013, diseases of the nervous system and external causes of mortality were the leading underlying causes of death among children aged 1-17 (23.8% each). Among the external causes of mortality the majority were transport accidents.

The next most frequent causes of death were Malformations, Deformations and Chromosomal Abnormalities (14.28%) and Neoplasms (14.28%). Numbers attributable to other causes were very small.

3.3.6 Variations in Child Mortality by Locality 2011-2013

Relative to the size of the actual underlying population of the locality, Central Halifax (Park, Skircoat, Sowerby Bridge and Town Wards) had the highest age specific mortality rates (3.69 per 10,000 per year) and therefore the greatest burden of Child Mortality (ages 1-17).

	3 year average age specific child mortality rate per 10,000 (2011 – 2013)
Central	3.69
Halifax NE	0.92
Lower Valley	0.60
Upper Valley	1.08

3.3.7 Child/Infant Mortality rates by deprivation (categorized by the Index of Multiple Deprivation IMD 2010)

The majority of both Infant and Child Mortalities in Calderdale (2011-2013) were to children who were categorized as living within the two worst deprived quintiles. That is, 43% of deaths occurred in in the worst deprived quintile and 38% in the second worse deprived quintile. No child deaths (1-17) occurred in the most affluent quintile in the period 2011-2013. Childhood mortality rates by deprivation quintile per 10,000 of the underlying population are also highest in more deprived quintiles. Meaning the Calderdale mortality rates are as follows:

IMD Quintile (1=Most Deprived 5= Least Deprived)	3 year average mortality rate per 10,000 - 2011/13 (children aged 1-17)
1	2.9
2	2.3
3	1.0
4	0.7
5	0.0

3.3.8 Child mortality rates by age and deprivation

The numbers of deaths are too small to draw any meaningful conclusions by looking at Child Mortality (1-17) rates broken down by age **and** deprivation quintile. Although the highest rate of death can be seen for those aged 1 -4 in the most deprived quintile this is not statistically significantly higher than any other group.

3.4 Conclusion

In conclusion, the key messages from the CDOP report for Calderdale are:

- There were 15 Calderdale child deaths in 2013/14, amongst the lowest for a decade, of which two-thirds were infants

- There were 155 Calderdale child deaths in the seven years of operation of CDOP, of which 90% have completed reviews
- The CDOP completed 13 child death reviews for Calderdale in the year to 31/03/15, of which 38% (five cases) died during in that year
- Death rates for children and infants are significantly higher in the Asian Pakistani than White-British ethnic group in the six years of CDOP
- Child death rates are highest in Halifax Central and in the lowest two quintiles of deprivation
- Most Calderdale child deaths have been categorised as being due to 'chromosomal, genetic and congenital anomalies' or 'perinatal /neonatal event' over the last seven years
- 38% of Calderdale child deaths reviewed/completed in 2014/15 were modifiable factors identified, which is higher than any of the previous six years
- One of the Calderdale child deaths reviewed/completed in 2014/15 was subject to a CPP or statutory orders, and the CDOP did not recommend a Serious Case Review for any case
- The functioning of the CDOP continues to outperform the national average on multiple parameters including timeliness of reviews and completeness of data

4 Data analysis – Kirklees

4.1 Child Deaths reported to the Kirklees CDOP Team

A total of 36 deaths of children were reported to Kirklees Child Death Review Team between 1 April 2014 and 31 March 2015.

This is the lowest number recorded since the introduction of Kirklees CDOP

Of the 36 reported deaths, 23 have been considered at the Child Death Overview Panel and a conclusion reached in 20 cases (this translates to 55% concluded within the year after death an increase of 6% from 2013/14 and compares with the National average of 38%).

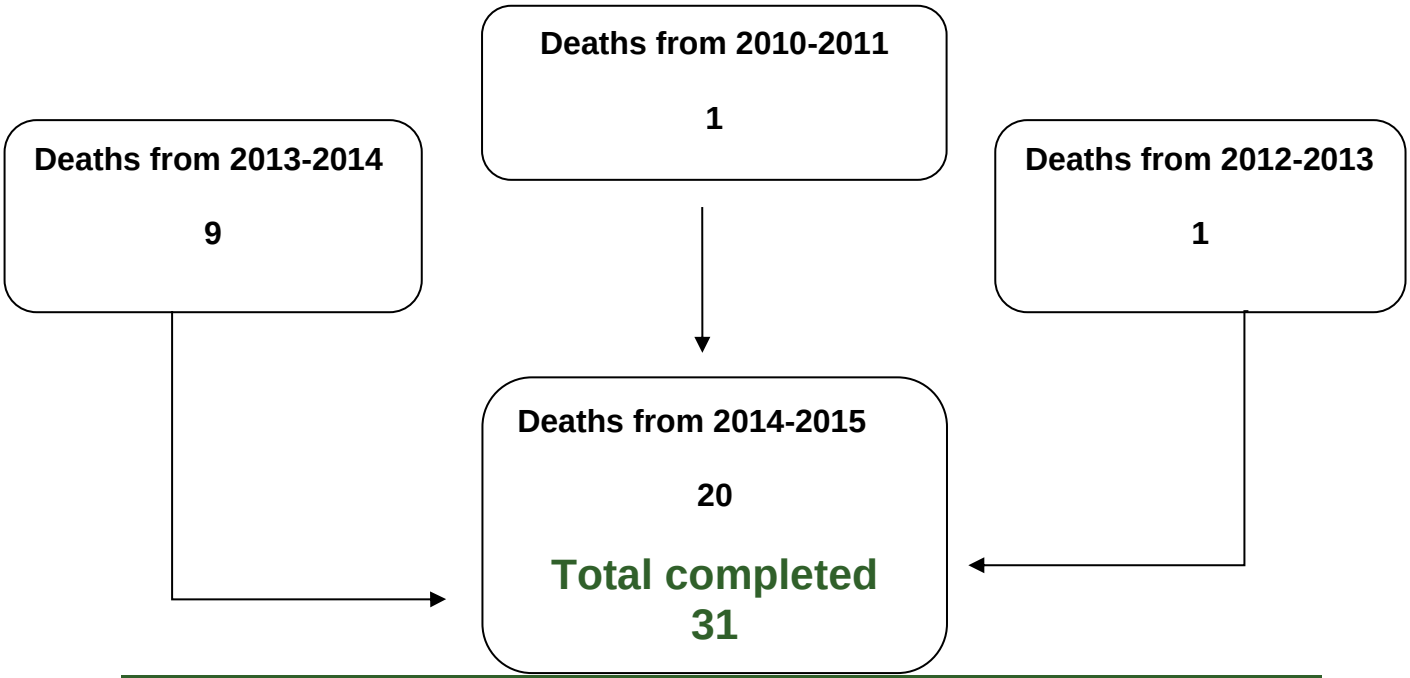
The remaining deaths will be discussed within the 2015/16 financial year or when sufficient information is available.

It is of note that 3 cases were reported late and discussions have continued at Panel in respect of the reasons for this including whether the correct notification process was followed, and gaps in information from agencies.

4.2 Child Death Reviews Completed at CDOP

31 Kirklees child deaths were reviewed and completed between 1st April 2014 and 31st March 2015.

20 of the deaths occurred within this timeframe; the others were historical cases which had been awaiting further information or awaiting investigations, inquests or reviews.



Categories of **completed** cases were recorded as follows

Category of death 2014-2015	Number
Deliberately inflicted injury, abuse or neglect (category 1)	**0**
Suicide or deliberate self-inflicted harm (category 2)	**0**
Trauma and other external factors (category 3)	**2**
Malignancy (category 4)	**3**
Acute medical or surgical condition (category 5)	**2**
Chronic medical condition (category 6)	**2**
Chromosomal, genetic and congenital anomalies (category 7)	**10**
Perinatal/neonatal event (category 8)	**9**
Infection (category 9)	**1**
Sudden unexpected, unexplained death (category 10)	**2**
Unknown category	**0**

The **completed** child death reviews were recorded under the following age groups:

Age of child	2014-2015
0-27 days	**16**
28 days- 364 days	**<5**
1 year-4 years	**<5**
5-9 years	**<5**
10-14 years	**<5**
15-17 years	**<5**

65% of cases concerned children under one year old, in line with the national average of 66%.

Ethnicity was recorded in 93.5% of completed cases. The categories were noted as follows:

Ethnicity: completed cases 2014-2015	
White: English/Welsh/Scottish/Northern Irish/British	**17**
White: Any Other White background	**<5**
Mixed/multiple ethnic groups: White & Black Caribbean	**0**
Mixed/multiple ethnic groups: White & Asian	**0**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	**0**
Asian or Asian British: Indian	**0**
Asian or Asian British: Pakistani	**9**
Black/Black British: African	**<5**
Arab	**0**

Throughout the period of CDOP operation, approximately 30% of deaths in Kirklees have involved children of Pakistani origin.

Of the 43 reported deaths during 2012-2013, 19% were of Pakistani origin. It was noted within the report for that period that his data would be monitored in case a reducing trend became evident.

Of the 39 cases reported within 2013-2014, 17% were of Pakistani origin suggesting that there was some consistency emerging in respect of the reducing trend.

The figures for 2014/15 however identify that 29% of child deaths were of Pakistani origin.

4.3 General context of infant and childhood deaths in Kirklees

4.3.1 Infant and child mortality, 2012-14

Summary tables:

2012-14	Infant mortality (age < 1 yr)	Child mortality (age 1-19 yrs)	Analysis by smaller age range			
	Rate per 1000 live births	Rate per 10,000 population	1-4	5-9	10-14	15-19
Kirklees	4.6	1.7	2.9	Suppr	Suppr	2.1
Yorkshire & Humber	4.1	1.5	1.7	0.9	0.8	2.4
England & Wales	3.9	1.5	1.7	0.8	0.9	1.8

Data suppressed where rates derived from 3-year average mortality values of 3 or below

Kirklees trends	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
IM rate per 1000 live births	6.5	6.1	5.6	5.3	4.7	5.2	4.6
CM rate per 10k popn (age 1-19)	2.5	2.2	2.1	2.1	2.0	1.8	1.7

Deprivation quintile – 2012-2014 (3 year average)	<1 yr			1-17 yrs		
	Deaths	Live births	Infant mortality rates per 1,000 live births	Deaths	Population 2013	Mortality rates per 10,000 underlying population*
1 - worst deprived 20%	14.0	2171.0	6.4	Suppr	32260	Suppr
2	7.0	1483.7	4.7	4.3	22811	1.9
3	Suppr	701.0	Suppr	3.3	12493	2.7
4	Suppr	811.0	Suppr	Suppr	15568	Suppr
5 - least deprived	Suppr	402.3	Suppr	Suppr	9623	Suppr

Data suppressed where rates derived from 3-year average mortality values of 3 or below

Mortality data provided by ONS/HSCIC; local population denominator uses GP-registered population (mid-year extract, provided by WYCSA)

4.3.2 Infant mortality, 2012-14

- Infant mortality (IM) rates in Kirklees, Yorkshire & The Humber and England & Wales continue to show a general downward trend, although the Kirklees rate remains higher than regional and national rates.
- North Kirklees continues to show a higher rate than South Kirklees (5.8 per 1,000 live births, vs 3.5).
- Of the six localities, Batley, Birstall & Birkenshaw has the highest rate in 2012-14 (8.4) – this is the highest rate seen in any of the localities since 2006-08.

- Although Dewsbury & Mirfield has the second highest locality rate in 2012-14 (5.0), it is the lowest rate yet recorded for this locality and is half the Dewsbury & Mirfield value of ten years ago (2003-05 IM rate = 10.2).
- IM rates are highest in the most deprived quintile (6.4); rates in the least deprived quintiles have been suppressed due to very low numbers.

4.3.3 Child mortality, 2012-14

- Child mortality (CM) rates in Kirklees, Yorkshire & The Humber and England & Wales continue to show a general downward trend, although the Kirklees rate remains higher than regional and national rates.
- The North Kirklees CM rate (age 1-19) is lower than South Kirklees .
- The Valleys has the highest number of deaths in the 1-19 age range.
- Unlike infant mortality, CM rates do not appear to correlate with deprivation quintile.
- The most common underlying cause of death amongst children aged 1-17 was neoplasms (27%), followed by external causes of morbidity and mortality (25%, of which the majority were transport accidents or other external causes of accidental injury).

Notes

- As the underlying number of infant and deaths is relatively low, the patterns identified above cannot be described as statistically significant. Direct comparisons between figures should be carried out with caution - it is not accurate to state, for example, that Infant Mortality or Child Mortality rates in one area of Kirklees are significantly better or worse than another. However, the numbers present a general picture of rates across Kirklees; the underlying messages that infant and child mortality rates are falling and that Infant Mortality rates are higher in more deprived areas are supported by the broader evidence base.
- Rates are only reported where the underlying 3-year average mortality value is greater than 3.0.

5 SUDIC Summary 2014-2015

An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

All unexpected child deaths are reviewed in depth by the SUDIC Paediatrician who collates a file for each child. The review takes into account the involvement of all agencies with the child and their family. The Designated Doctor for Child Deaths undertakes the functions via a service level agreement between the CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT). Once the SUDIC Paediatrician considers the review to be complete, they present the case details to the other members of the Panel which are then discussed along with all other child deaths. The members of the bi-monthly CDOP are able to offer a further level of scrutiny to the SUDIC Review.

When a child death occurs within Calderdale but the child is from another area, the Calderdale and Kirklees SUDIC Paediatrician undertakes all the initial investigations and passes this information on to the Local Safeguarding Children Board of the child's residence area.

During 2014/15 there were 7 categorised SUDIC deaths in Calderdale and 6 in Kirklees.

6 Implementation of 2013/2014 recommendations

Recommendation	Action	Outcome
Get CAMHS / Public HEALTH eHNA to do specific talk RE Emotional Wellbeing / Self Harm / Suicide at CDOP meeting.	We will bring the findings from the forthcoming suicide audit and young people's emotional wellbeing survey to CDOP panel to inform learning Data Re patterns/ trends to be collected and analysed for recommendations Include learning from Serious Case Reviews Re suicide.	To be carried forward and presented to the November 2015 CDOP Suicide audit discussed and agreed nothing specific that would inform the work of the CDOP
Further links to be developed with regional CDOP links to establish regional / local themes and what good practice can be shared and support for CDOP coordinators to improve practice.	Share audits from other CDOP's	Regional CDOP networks are being established. Calderdale and Kirklees will engage with any regional and national networks. Information sharing e-network to be developed Calderdale and Kirklees have contributed to national CDOP database consultations. Results will be fed

		back summer 2016
Promotion of child safety e-learning package.	Evaluate numbers of participants and impact. Promote through: -2 year funding – incentives to complete training – endorsed by CAPT - A&E – target parents of children who attend? - Schools - Foster Carers and fostering teams including private fostering - Childminders - Adoption Team	From April 2014 to Sept. 2015 – 891 completed the Kirklees Child Accident Prevention e-learning Breakdown of Kirklees figures to be carried out as to who and from where had completed the course. KSCB Learning & Development workstream to evaluate and bring to next Development Day in March 2016
Coroners: attendance and contribution to CDOP	Chairs of both LSCB's to write to Supervising Coroner to ask for attendance or some solution / suggestion.	Letter sent to Coroners from Board Chairs and satisfactory replies received offering support with any queries A more positive relationship is developing resulting in increased contribution from the appropriate coroner in individual cases
Further develop Child Death	Safeguarding Week	Learning and raising

Review training and raise awareness.	in March in Calderdale Raise awareness of pathway and notification process across both LSCB areas – panel members to disseminate to their respective agencies. Cross reference with raising quality of Form Bs below.	awareness highlighted in newly established CDOP newsletter Wide circulation of newsletter to agencies and GP Safeguarding Leads through Board members
Raise quality of Form B's.	Change to using electronic forms with secure e-mail addresses. Add clarity re: agencies needing to look at wider family circumstances when collating the necessary information. Also need to stress that their input is required in order to complete the Child Death Review. Panel members to quality assure Selected forms. Training for midwives, obstetricians and health visitors on how to complete the forms with particular emphasis on the	Requests for electronic forms and returns are now done by secure e-mail systems. Information to be put on website on how to complete and return Agencies now quality assure forms before return to ensure information complete Highlight in newsletter what are Modifiable Factors and the information required Training for frontline workers deferred to 2015/16 To have a running log of information missing and agencies identified in order to provide

	need to identify modifiable factors e.g. BMI / parental smoking Once the standard has been set: Escalate through LSCB's re: any non-compliance.	evidence for escalation.
Regular 'Messages from Child Death Review Process' Newsletter.	Annual newsletter to be piloted with contributions from Panel members. To include safety messages (national and local) and information re: the child death notification and review process	First newsletter completed and circulated. To be bi-annual and to follow on from Development Days – next one November/December 2015 Anything that arises in between times to be flagged up on website

7 Recommendations for 2015/16

Category	Proposed action	Lead
1. CDOP Process	Training for midwives, obstetricians and health visitors on how to complete the forms with particular emphasis on the need to identify modifiable factors e.g. BMI / parental smoking (deferred from 2014/15)	CSCB / KSCB managers
	Develop an appeals process whereby parents can request further consideration of cases, even some years after initial case considered	CSCB / KSCB managers
	Update Forms A and B to ensure they are user friendly and promote the submission of accurate and appropriate data, with a focus on improving the quality of data received on family members	CSCB / KSCB coordinators
	Develop clear web-based guidance on how to complete forms	CSCB / KSCB managers
	Ensure a clear process is in place to take forward any learning from cases reviewed, with a clear process for recording any action taken.	CDOP chairs
2. Emotional health and wellbeing	Public Health to present information on potential risk factors associated with emotional health and wellbeing to CDOP to inform future discussions re relevant cases	Public Health Calderdale / Kirklees

	When required, undertake rapid evidence review of specific risk factors to support potential action	Public Health Calderdale / Kirklees
3. Smoking as a Modifiable Factor	Continue with programme around smoking and with the 'smoke free environment programme' in both Calderdale and Kirklees	Public Health Calderdale / Kirklees
	Consider the possible role of e-cigarettes to support reduction in smoking, reporting back to CDOP panel when evidence reviewed	Public Health Calderdale / Kirklees
4. Genetics (consanguinity)	Ensure there are specific services in both Calderdale and Kirklees that focus on raising genetic awareness in the community	Public Health Calderdale / Kirklees
	Ensure the system is aware of and signposts to genetic awareness services as appropriate	CSCB / KSCB managers
	Contact Bradford to see whether there is any learning from their activities or from the Born In Bradford project and to update the CDOP in good practice or recommendations	Public Health Calderdale / Kirklees
	Ensure all families with a Category 7 (genetic) death received genetic counselling	CDOP chairs
5. Modifiable Factors from last 5 years	Undertake a retrospective analysis of the recorded modifiable factors from the last five years for Calderdale and Kirklees, along with any national data, to ensure we have not missed any opportunities to	CDOP coordinators

	address any gaps. Present to CDOP development session in 2016/17	